IBEW Local 38 Health & Welfare Plan: Inside Wiremen CBA

Coverage for: Single or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact the Fund Office. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at anthem.com or call 1-833-639-1634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network : $250 single / $500 family (Wellness Tier); $500 single / $1,000 family (Non-Wellness Tier) Non-Network : $750 single / $1,500 family (both Tiers).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical:** Network: $2,000 single / $4,000 family (Wellness Tier); $3,000 single / $6,000 family (Non-Wellness Tier). Non-network: None. **Prescription**: Network: $7,200 single / $14,400 family (Wellness Tier); $6,200 single / $12,400 family (Non-Wellness); Non-network: None.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Cost sharing for prescription drugs, premiums, Copays, balance-billing charges, and health care the plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-833-639-1634 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Non-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		Non-network Provider (You will pay the most)	
		Wellness Tier	Non-Wellness Tier	Both Tiers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay, (Office Visits); Deductible does not apply		50% coinsurance of allowed amount	20% coinsurance applies to all in-network consultations
	Specialist visit	$20 copay, (Office Visits); Deductible does not apply		50% coinsurance of allowed amount	20% coinsurance applies to all in-network consultations
	Preventive care/screening/ immunization	No charge.		50% coinsurance of allowed amount	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	IBEW 38 and Laborers Fund Health Clinic Services	No charge. Plan pays 100% of services		Not applicable.	None.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Preauthorization is required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Optumrx.com	Generic prescription drugs – Tier 1	$10 copay/prescription (retail); $20 copay/prescription (mail order); Deductible does not apply.			Retail-30-day supply limit; Mail Order-90-day supply limit. If you choose a non-preferred brand drug that is not listed on the Plan's Formulary, your physician must first submit a preauthorization request. Certain medications may also be subject to the Utilization Management Program administered by the Pharmacy Benefit Manager (PBM). You are responsible for the cost difference between a brand name prescription and a generic prescription if a generic is available. Participation in the Variable Copay Program may apply to some medications, and co-insurance for these drugs may vary, up to 100% of the discounted cost.
	Preferred brand prescription drugs – Tier 2	$25 copay/prescription (retail); $50 copay/prescription (mail order); Deductible does not apply.			
	Non-preferred brand prescription drugs -Tier 3	$40 copay/prescription (retail); $80 copay/prescription (mail order); Deductible does not apply.			
	Specialty drugs – Tier 4	$50 copay/prescription (retail); $100 copay/prescription (mail order); generic, if available, must be tried first. Deductible does not apply.			

For more information about limitations and exclusions, see Summary Plan Description.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		Non-network Provider (You will pay the most)	
		Wellness Tier	Non-Wellness Tier	Both Tiers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
	Physician/surgeon fees	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
If you need immediate medical attention	Emergency room care	$100 copay and 20% coinsurance	$100 copay and 30% coinsurance	$100 copay and 20% coinsurance of allowed amount	$100 copay waived if admitted for network providers and Non-network providers.
	Emergency room care (Non-Emergency Services)	$100 copay and 20% coinsurance	$100 copay and 30% coinsurance	50% coinsurance of allowed amount if non-emergency	$100 copay waived if admitted for network providers and Non-network providers.
	Emergency medical transportation	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
	Urgent care	$20 copay for office visit		50% coinsurance of allowed amount	20% coinsurance applies to all in-network consultations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Preauthorization is required before you are admitted as an inpatient in a Hospital.
	Physician/surgeon fees	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Preauthorization is required for inpatient admissions must be preauthorized.
	Inpatient services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	
	Inpatient/Outpatient Alcohol and Substance Abuse Services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	
If you are pregnant *Covered for subscriber and spouse only.	Office visits	$20 copay		50% coinsurance	**Coverage for you or your spouse only**. Cost sharing does not apply to certain preventive services. Depending on the type of services, copay or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	
	Childbirth/delivery facility services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	

For more information about limitations and exclusions, see Summary Plan Description.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		Non-network Provider (You will pay the most)	
		Wellness Tier	Non-Wellness Tier	Both Tiers	
If you need help recovering or have other special health needs	Home health care	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
	Rehabilitation services (physical therapy)	$20 copay, 20% coinsurance of allowed amount	$20 copay, 30% coinsurance of allowed amount	50% coinsurance of allowed amount	Limited to 25 visits per benefit period.
	Habilitation services (occupational therapy)	$20 copay, 20% coinsurance of allowed amount	$20 copay, 30% coinsurance of allowed amount	50% coinsurance of allowed amount	Limited to 25 visits per benefit period.
	Habilitation services (speech therapy)	$20 copay, 20% coinsurance of allowed amount	$20 copay, 30% coinsurance of allowed amount	50% coinsurance of allowed amount	Limited to 25 visits per benefit period.
	Skilled nursing care	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Limited to 60 Days
	Durable medical equipment	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	Rental cost covered up to purchase price. Coverage may be available to purchase pending Prior Approval.
	Hospice services	20% coinsurance of allowed amount	30% coinsurance of allowed amount	50% coinsurance of allowed amount	None
If your child needs dental or eye care	Children's eye exam	Based on VSP Schedule of Benefits.		Based on VSP Schedule of Benefits.	Once every 12 months if age 18 and younger. Once every 24 months if over the age of 18.
	Children's glasses	Based on VSP Schedule of Benefits.		Based on VSP Schedule of Benefits.	None.
	Children's dental check-up	Based on Delta Dental PPO Summary of Dental Benefits.		Based on Delta Dental PPO Summary of Dental Benefits.	Four exams per 12-month period included. Annual maximums: $1,500 Delta Dental PPO; $1,250 Delta Dental Premier; $1,000 non-participating providers.

For more information about limitations and exclusions, see Summary Plan Description.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Routine Foot Care
- Weight Loss Programs
- Non-emergency care when traveling outside U.S

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care (10 visits)
- Limited emergency care when traveling outside
- Dental Care (Adult)
- Hearing Aids ($500 maximum every 5 years)
- Private Duty Nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 216.431.7738. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1.800.318.2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 216.431.7738. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, also insert applicable State Department of Insurance contact information.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 216.431.7738.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216.431.7738.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 216.431.7738.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216.431.7738.]
[Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 419-248-2401 uff.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exclusions, see Summary Plan Description.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$1,950
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,850**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$414
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$934**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office: 216-431-7738.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.